General Assembly

Raised Bill No. 409

February Session, 2006

LCO No. **2146**

02146_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT ESTABLISHING THE NUTMEG HEALTH PARTNERSHIP INSURANCE PLAN.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2006*) There is established a Nutmeg Health Partnership Insurance Plan. The plan shall consist of the measures set forth in sections 2 to 7, inclusive, of this act and sections 38a-476c of the 2006 supplement to the general statutes, 38a-497, 38a-554 of the general statutes and subparagraph (B) of subdivision (15) of section 38a-816 of the 2006 supplement to the general statutes, as amended by this act, for the purpose of making health insurance accessible and affordable for residents of this state.

Sec. 2. (NEW) (*Effective October 1, 2006*) (a) Notwithstanding the provisions of chapter 700c of the general statutes, the Insurance Commissioner may approve any individual health insurance policy or certificate which contains the minimum coverages or benefits set forth in section 38a-503c and subsection (c) of section 38a-504 of the general statutes in addition to those required under subsection (c) of section 38a-505 of the general statutes.

(b) Notwithstanding the provisions of chapter 700c of the general statutes, the Insurance Commissioner may approve any individual health insurance policy or certificate which (1) contains the following minimum coverages or benefits set forth in chapter 700c of the general statutes: Subdivision (2) of subsection (b) of section 38a-476, sections 38a-476b, 38a-483c, 38a-489, 38a-496, 38a-498a, 38a-502, 38a-503b and 38a-503c and subsection (c) of section 38a-504 of the general statutes, in addition to those required under subsection (c) of section 38a-505 of the general statutes, and (2) offers the following minimum coverages or benefits set forth in chapter 700c of the general statutes as options: Sections 38a-488a, 38a-490 to 38a-490c, inclusive, 38a-491a, 38a-492 to 38a-493, inclusive, 38a-498, 38a-503, 38a-503d, 38a-503e, subsections (a) and (b) of section 38a-504, 38a-504a to 38a-504g, inclusive, and sections 38a-507 to 38a-509, inclusive, of the general statutes, provided the insurer, at the time of initial issuance and upon renewal, shall offer the options specified in subdivision (2) of this subsection and receive the acceptance or declination of the insured, in writing, which offer shall include a description of the coverages or benefits and the cost associated with each such coverage or benefit.

Sec. 3. (NEW) (*Effective July 1, 2006*) (a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner; and

(2) "Ineligible population" means (A) part-time employees, seasonal employees and independent contractors who are not eligible to participate in a group health insurance policy offered by an employer or in any other group health insurance policy, as determined by the commissioner, and (B) retired employees under the age of sixty-five who are not eligible to participate in a group health insurance policy offered by a former employer or in any other group health insurance policy, as determined by the commissioner.

(b) Notwithstanding the provisions of chapter 700c of the general statutes, the Insurance Commissioner may approve any group health insurance policy or certificate which does not contain all the minimum

coverages or benefits set forth in chapter 700c of the general statutes, provided such policy or certificate is approved only for issue to the ineligible population in this state.

Sec. 4. (NEW) (*Effective October 1, 2006*) Not later than October 1, 2007, each health care provider licensed in this state shall submit claims or request for payment to insurance companies with respect to medical services and treatment rendered by such provider in electronic format.

Sec. 5. (NEW) (*Effective October 1, 2006*) No physician licensed under chapter 370 of the general statutes who does not have a contract with a third party payer or who provides medical services or treatment to persons who do not have health insurance coverage shall charge fees for such services or treatment that exceed two hundred per cent of those fees allowed by the federal Medicare program for such services or treatment.

Sec. 6. (NEW) (*Effective October 1, 2006*) Each physician licensed under chapter 370 of the general statutes and engaged in the private practice of medicine in this state shall:

(1) Post, in public view within the waiting room in such physician's office, in a conspicuous manner, a list of the twenty procedures most frequently performed in such office for such physician's specialty and the current charges for each such procedures;

(2) Provide, upon request of the patient or such patient's designee, an estimate of the costs of any service or treatment to the patient or his or her designee prior to the service or treatment being rendered; and

(3) Provide an itemized receipt to the patient or such patient's designee for any payment made at such physician's office by or on behalf of such patient, which shall specify the services rendered to the patient and the charges for each such service.

Sec. 7. (NEW) (*Effective October 1, 2006*) (a) The Commissioner of

Public Health and the Insurance Commissioner, in consultation with licensed providers of health care, health insurance companies doing business in this state and consumers designated by said commissioners, shall create a physician report card which shall contain data relative to generally accepted performance measures designed to allow the Department of Public Health to provide consumers with information on the performance of physicians and the effectiveness of care provided by each physician and to permit consumers and insurance companies to compare physicians by criteria concerning quality.

(b) Each physician licensed under chapter 370 of the general statutes shall furnish any information required by the Commissioner of Public Health, upon the request of said commissioner, relative to performance measures. Said commissioner shall publish such information and comparative data on the Internet web site of the Department of Public Health.

Sec. 8. Section 38a-476c of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(a) The Insurance Commissioner shall approve any health insurance policy or contract, including, but not limited to, a policy or contract filed by a health care center, that uses variable networks and enrollee cost-sharing as set forth in subsection (b) of this section if (1) the policy or contract meets the requirements of this title, (2) the policy or contract form or amendment thereto filed with the commissioner is accompanied by a rate filing for the policy or contract and (3) the commissioner finds that the rate filing reflects a reasonable reduction in premiums or fees as compared to policies or contracts that do not use such variable networks and enrollee cost-sharing.

(b) Such policies and contracts shall be limited to policies and contracts that: (1) Offer choices among provider networks of different size; (2) offer different deductibles depending on the type of health

care facility used; **[**or**]** (3) offer prescription drug benefits that use any combination of deductibles, coinsurance not to exceed thirty per cent or copayments, including combinations of such deductibles, coinsurance or copayments at different benefit levels; or (4) require the use of a mail order pharmacy.

Sec. 9. Section 38a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

[Every**]** Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended or renewed in this state on or after October 1, **[**1982**]** 2006, shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child marries, ceases to be a dependent of the policyholder **[**,**]** or attains the age of **[**nineteen if the child is not a full-time student at an accredited institution, or attains the age of twenty-three if the child is a full-time student at an accredited institution**]** twenty-six.

Sec. 10. Section 38a-554 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38a-553, as amended, and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee, who shall be considered a dependent for the purposes of this section; and (3) dependent unmarried children **[**,**]** who are under the age of **[**nineteen or are full-time students under the age of twenty-three at an accredited institution of higher learning**]** twenty-six.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subdivisions (3) and (4) of this subsection: (1) Notwithstanding any provision of this section, upon layoff, reduction of hours, leave of absence, or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for the periods set forth for such event under federal extension requirements established by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA), except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); (3) regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence; (4) regardless of an individual's eligibility for other group insurance, upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan; (5) the coverage of any covered

individual shall terminate: (A) As to a child, the plan shall provide the option for said child to continue coverage for the longer of the following periods: (i) At the end of the month following the month in which the child marries, ceases to be dependent on the employee or attains the age of **[**nineteen**]** twenty-six, whichever occurs first. **[**, except that if the child is a full-time student at an accredited institution, the coverage may be continued while the child remains unmarried and a full-time student, but not beyond the month following the month in which the child attains the age of twenty-three.**]** If on the date specified for termination of coverage on a dependent child, the child is unmarried and incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (ii) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); (B) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); and (C) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act; (6) as to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time,

continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in 29 USC 1162, as amended from time to time. Any continuation of coverage required by this section except subdivision (4) or (6) of this subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subdivision (1), (2) or (5) of this subsection. The employer shall not be legally obligated by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, as amended, to pay such premium if not paid timely by the employee.

(c) The commissioner shall adopt regulations, in accordance with chapter 54, concerning coordination of benefits between the plan and other health insurance plans.

(d) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group plan. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual comprehensive health care plan.

Sec. 11. Subparagraph (B) of subdivision (15) of section 38a-816 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(B) Each insurer, or other entity responsible for providing payment to a health care provider pursuant to an insurance policy subject to this section, shall pay claims not later than forty-five days after receipt by the insurer of the claimant's proof of loss form or the health care

provider's request for payment filed in accordance with the insurer's practices or procedures provided such request is in electronic format, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall (i) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and (ii) pay claims for payment or reimbursement under the contract not later than thirty days after the insurer receives the information requested.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2006*	New section
Sec. 2	*October 1, 2006*	New section
Sec. 3	*July 1, 2006*	New section
Sec. 4	*October 1, 2006*	New section
Sec. 5	*October 1, 2006*	New section
Sec. 6	*October 1, 2006*	New section
Sec. 7	*October 1, 2006*	New section
Sec. 8	*October 1, 2006*	38a-476c
Sec. 9	*October 1, 2006*	38a-497
Sec. 10	*October 1, 2006*	38a-554
Sec. 11	*October 1, 2006*	38a-816(15)(B)

Statement of Purpose:

To establish the Nutmeg Health Partnership Insurance Plan for the purpose of making health insurance accessible and affordable for residents of this state.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]